

Public Service Program SELF-CERTIFICATION of Income for

City of / Town of / County of _____ **CDBG Funded Activity**

Name of Public Service: _____

HUD Code: _____

Page 1 to be filled out by Participant

Part I: Confidential Participant / Beneficiary HUD Demographic Information

(This section is voluntary.)

Ethnicity (Select One)		<input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Hispanic
Race (Select One)			
<input type="checkbox"/> White	<input type="checkbox"/> Am. Indian/Alaskan Nat. & White		
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian & White		
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American & White		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Am. Indian/Alaskan & Black/African		
<input type="checkbox"/> Nat. Hawaiian/Other Pacific Isl.	<input type="checkbox"/> Other Multi-Racial		
Other Demographic Data (Select all that Applies)			
<input type="checkbox"/> Female Head of Household	<input type="checkbox"/> Single / Non Elderly		
<input type="checkbox"/> Participant Disable	<input type="checkbox"/> Related/Single Parent		
<input type="checkbox"/> Veteran	<input type="checkbox"/> Related/Two Parent		
<input type="checkbox"/> Elderly	<input type="checkbox"/> Other (_____)		

Part II: Confidential Participant / Beneficiary Income Certification

(Must be completed and signed prior to providing public service.)

My total family size consists of _____ members, and the total gross annual income* for all adult members is \$_____.

*Gross annual income must include all sources of income (wages, child support, SSI, unemployment, pension, income from assets, etc., but does not include the income of live-in aids, per 24 CFR 5.403).

I certify that the information given on this form is true and accurate to the best of my knowledge. I am aware that there are penalties for willfully and knowingly giving false information on an application for Federal or State funds, which may include immediate repayment of all Federal or State funds received and/or prosecution under the law. I understand that the information on this form is subject to verification by state or federal personnel as part of compliance monitoring.

Participant / Beneficiary Information:

Signature: _____ Date: _____

Name (print): _____

Physical Home Address: _____, (City) _____

Public Service Program SELF-CERTIFICATION Verification by

City of / Town of / County of _____ for CDBG Funded

Page 2 to be filled out by Program Operator

Public Service Information:

Name Public Service(s): _____

Name of Agency Providing the Public Service: _____

Address where Public Service is being provided: _____, City _____

Public Service Funded By: Grant #: _____ - Or - PI Waiver in Fiscal Year: _____

Program Service Area: Citywide - Or - County wide - Or - Other (describe): _____

Participant / Beneficiary Family Income and Location Verification:

Effective Date of the Income Limit Chart being used: _____

- Family is: 30% or less (Extremely Low Income)
 31%-50% (Low Income)
 51%- 80% (Moderate Income)
 Over 80% of median income: **NOT ELIGIBLE FOR CDBG ASSISTANCE**

Program Operator must:

- 1) Print the current HCD Income limits from the HCD website (NOT HUD's), and
- 2) Circle the applicable family size and annual income on HCD limit printout, and
- 3) Include the copy of the circled printout in the program's applicant file; and
- 4) Must complete confidential demographic data, if participant/beneficiary leaves blank.

Name of Participant / Beneficiary: _____

Physical home address is: Within Service Area Outside of Service Area

Note: Significant number of program participants/ beneficiaries must reside in the program service area.

Program Operator Certification: *I certify that the Participant / Beneficiary demographic data and public service information is true and correct, to the best of my knowledge. I certify that, using the current HCD annual income publication compared to the stated family size and income, the income level shown above is true and correct. I certify that Participant / Beneficiary residency status is true and correct, per the requirements of 24 CFR 570.486(b) and/or (c) as applicable.*

Note: This completed certification, whether Beneficiary was assisted or not, must be maintained in the Program file for review at time of monitoring.

Printed Program Operator Name (printed)

Job Title

Signature:

Date:

Eligibility is valid until (three years after signed certification) Date: _____